Vermont Agency of Human Services

Office of Vermont Health Access

Provider Manual

Dental Supplement

Section 1 DENTAL

Introduction

This section of the Vermont Medicaid Dental Manual contains billing information, an alphabetical listing of reimbursable charges and specific instructions for completion of the Dental claim forms.

Vermont Medicaid **currently** accepts the J510 (1994 version) and the J588 (1999 version) of the American Dental Association Claim Forms. If you are billing CDT Codes the appropriate forms are the ADA J510 and J588. If you are billing CPT Codes the form to use is the CMS-1500 08/05 Claim Form.

With the implementation of NPI the only claim form that can accommodate the NPI and Taxonomy codes is the ADA 2006 form. All dental providers should use this form in their NPI implementation. However, dentists using the Dentrix system have identified a problem with patient data placement. Therefore, VTMedicaid will accept patient data in either box 12 or 20 of ADA 2006, until Dentrix rectifies its system problem.

Dentists using Eagle Soft cannot generate a correct ADA 2006 claim until the fall. VTMedicaid will continue to accept the 1994 claim form with the Medicaid ID# from Eagle Soft users until Eagle Soft becomes NPI-compliant.

If your practice has not converted to the ADA 2006 form, please contact EDS immediately so we can work with you to come into compliance. With the exception of Eagle Soft users who may continue to use the 1994 claim form until compliance issues are settled, VTMedicaid intends to stop accepting the 1994, 1999 and 2002 claim forms after the first of July. If you are unable to meet the July deadline please call EDS Provider Services and we will work with you on a compliance plan.

EDS Help Desk:

In State: 800-925-1706

Out of State: 802-878-7871

See: CMS-1500 08/05 Supplement
Provider Manual

1.1 IMPORTANT REMINDERS

The current maximum adult benefit can be found in the Dental Procedure/Fee Schedule posted on-line at: www.vtmedicaid.com [follow the links to] Downloads; Manuals. There are no exceptions under the Medicaid rules to this allowed amount. General Assistance is an alternate option for beneficiaries if the maximum benefit has been reached and a dental emergency has arisen. Beneficiaries should be directed to their local DCF office for a General Assistance Voucher.

If a beneficiary reaches their 21st birthday and has received dental care during the course of the year the dental benefit already paid will be applied to the annual adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to the current adult maximum benefit and will not begin again until the start of the new calendar year.

VHAP (Vermont Health Access Program) aid categories do not currently have a dental benefit included in their list of reimbursable charges.

HIPAA

Providers are reminded that the form locators at the end of this Supplement are in regard to a paper transaction. Providers using HIPAA compliant software to submit electronic claims may access the electronic requirements at the Washington Publishing website : http://www.wpc-edi.com/Default_Gen.asp.

1.2 COVERED SERVICES

Dental charges are reimbursed for adults and children who are enrolled beneficiaries. Charges are reimbursable when provided by a licensed dentist (DMD or DDS) who is enrolled as a participating Medicaid provider.

Dental charges are defined as preventive, diagnostic or corrective procedures involving the oral cavity and teeth. Coverage of services and items is described in the Welfare Assistance Manual (WAM) sections M619 through M622.8 and can be accessed via the OVHA website at http://www.path.state.vt.us/districts/ovha/ovha5.htm.

The EDS web site contains the Vermont Medicaid Provider Manual and Supplements, including the CMS 1500 Supplement and Dental Supplement. The site is:
www.vtmedicaid.com

Changes to the manuals will be communicated to the provider network via *The Advisory* and banner pages on the weekly Remittance Advice Report. It is the responsibility of the provider to maintain their paper version of the manuals.

The OVHA uses CDT codes, and CPT codes to describe covered items. Certain covered items require prior authorization. For complete details see the Dental Procedure/Fee Schedule or the VTMedicaid Fee Schedule.

Exceptions to services and items covered by the OVHA can be made when serious detrimental health consequences may arise if the service or item is not provided. This is covered under

section M108 of the WAM. Any beneficiary interested in obtaining an exception to coverage may contact the Member Services Unit for the required forms.

1.3 BILLING INFORMATION

All billing by Dental providers must be completed on the acceptable dental claim forms or the electronic equivalent. The OVHA accepts the J510 (1994 version) and the J588 (1999 version) of the American Dental Association, Claim Forms. Certain services performed by a dental provider are considered medical in nature and should be billed on the CMS-1500 08/05 claim form or the electronic equivalent. Refer to the section entitled Dental Claim Form for specific instructions in completing the required fields on the dental claim forms. The CMS-1500 08/05 Supplement contains the necessary billing information to complete the CMS-1500 08/05 form.

ACCIDENT

The State Medicaid Program must recover payment from liable third parties in accident cases. The information contained on a claim form is vital in researching these accident cases.

When filing a Medicaid claim, when an accident may be involved, check the appropriate box in the accident fields and enter the date of the accident according to the appropriate billing instructions if applicable. The claim will deny if all accident fields are not completed.

ADVISORY

The *Vermont Health Access Advisory* is a periodic publication of the Claims' Processing Agent and OVHA. This newsletter provides important information that is necessary for accurate billing. It is often the first notification of a change in billing procedure. It is recommended that copies of the *Advisory* be retained by each provider and consulted whenever a question arises regarding the OVHA's policy or procedure until a revision of the Manual is received.

ANESTHESIA

For services billed on the CMS-1500 08/05 Claim Form, coverage is provided for anesthesia administered by an anesthesiologist who remains in constant attendance during the surgical procedure for the sole purpose of providing the anesthesia service or supervising its administration. The operating physician may not bill for anesthesia. The administration of anesthesia by the operating M.D. is considered included within the reimbursement for the surgery.

Local anesthesia, such as Novocain, or topical anesthesia used by dentists is not reimbursable as a separate service. It is covered in the reimbursement for the procedure.

See: CMS-1500 08/05 Supplement

ATTENDING PHYSICIAN/ATTENDING PRACTITIONER

An attending physician/dental provider is the physician/dental provider who actually performs the service. The attending provider must be enrolled as a participating or a non-participating Medicaid provider.

When billing on the CMS-1500 08/05 Claim Form, the attending provider number must appear in field 24k for each line of service being billed.

The 2006 Dental Claim Form requires the NPI # to be listed in field 49 and the billing provider taxonomy code to be listed in field 52A.

BANNER PAGE

The first page of the remittance advice (RA) is referred to as the "banner page". The banner page is often the first notification of a change in billing procedure. It is recommended that copies of the banner pages be retained by each provider and consulted until a revision of the Manual is received.

BILLING/SUPPLYING PROVIDER

The billing/supplying provider name, address and provider number which payment will be made to must appear in the appropriate field of the claim form. The billing/supplying provider information must appear identical to the format in which the billing/supplying provider enrolled with Medicaid. If you are rendering a service that requires the use of the CMS-1500 08/05 form, then please refer to the CMS-1500 08/05 billing instructions posted at: www.vtmedicaid.com. The ADA 1994 Claim Form requires the billing number to be listed in field 21, the 1999 ADA Claim Form requires this number to be listed in field 44.

The 2006 Dental Claim Form requires the NPI # to be listed in field 49 and the billing provider taxonomy code to be listed in field 52A.

CARRIER CODES

Carrier codes are two or three digit codes that identify other insurance carriers. They are required on all claims involving beneficiaries who have other insurance policies. These codes, like all other insurance information, can be obtained through the Eligibility Verification System (EVS). Also, the most frequently used codes are listed in the Provider Manual. For additional carrier codes, contact the Provider Services Unit.

CLAIM REQUESTS

When a Medicaid beneficiary or an attorney for a Medicaid beneficiary, requests a copy of a claim which has been paid by Medicaid, please inform them that copies must be requested from:

TPL Unit, OVHA
DCF
103 South Main Street
Waterbury, VT 05676-1201

CONTRACTUAL ALLOWANCE

Medicaid is the payor of last resort, and as such will not consider and pay amounts that are considered to be the contractual allowable amount of a primary insurer.

Providers must reduce the expected payment from Medicaid and note the contractual allowable adjustment of a primary insurer. When another insurance carrier has made a payment, you must add the contractual allowable adjustment amount to the payment and document the total in the appropriate field on your claim form.

Medicaid will consider payment based on the Medicaid allowed amount after deducting the other insurance payment and contractual allowable adjustment amounts.

DATE OF SERVICE

The billed date of service on the claim must be the date that the service was dispensed to the patient. The exception to this is when the beneficiary becomes ineligible after a customed item/service has been ordered, but before it can be dispensed, the date may be the actual date of the order. For example:

- When receiving orthodontics providers are asked to submit the claim when service is completed
- For crowns the start date is to be billed as the date of service

DENIED CLAIMS

The explanation of benefits (EOB) codes printed on the Remittance Advice (RA) explains the reason(s) why Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials, which pertain to the entire claim, are printed directly under the patient's name and the Internal Control Number (ICN) on the RA. Detail denials are printed under each billing detail on the RA. The RA contains up to ten header denials per claim and ten detail denials per billing line. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the Provider Services Unit.

See: Provider Manual Section 4

DETAIL PROCESSING

Each line on the claim form is called a “detail” and is processed individually. All of the details on a claim form have the same Internal Control Number (ICN). Individual processing means that one detail from a claim may appear on the RA in the Paid Claims section while another detail from the same claim may appear in the Suspended or Denied Claims section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

See: Provider Manual Section 4

DIAGNOSIS CODES

Diagnosis codes can be found in the ICD-9-CM coding book. It lists the three, four or five-digit code used to indicate the beneficiary's diagnosis. Any variation to the actual codes listed, such as leading or trailing zeroes will result in claim denial.

EPSDT PROGRAM -- WELL-CHILD HEALTH CARE

Vermont provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Medicaid beneficiaries under age 21. The goal of the program is to prevent illness, complications, and the need for long-term treatment by screening and detecting health problems in the early stages. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Medicaid claims. The Vermont Department of Health (DOH) assists in EPSDT outreach and education through its Partners in Health Program. Under an agreement to implement EPSDT services, the DOH has established protocols and standards for screening services, which are available to all providers.

Dental providers are asked to complete form locator 2 on the 1994 and 1999 claim form if the service being provided is for that of a beneficiary under the age of 21.

The 2006 Dental Claim Form requires this number to be listed in field 1.

FLUORIDES

Medicaid reimburses for fluorides when prescribed by a participating or non-participating physician or dentist for beneficiaries under age 21. Topical fluorides or fluorides in combination with vitamins are not covered.

See: Pharmacy Manual

HEADER PROCESSING

Information pertinent to an entire claim, including all details, is contained in the header of each claim. Examples are the beneficiary name and number. Errors in the header information may cause the entire claim to deny before the individual details are considered.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

HMOs are insurance plans and are treated as such by the OVHA. Medicaid beneficiaries covered by a commercial HMO must follow the rules of the HMO. Medicaid will make no payment for which an HMO is responsible or when the beneficiary has not followed the HMO rules. Providers may notify the patient that he or she is responsible for payment when HMO rules are not followed.

Medicaid will reimburse for HMO co-pay charges for physician office visits when the physician charge is capitated by the primary HMO.

HOSPITAL CALLS

Use procedure code D9420 (hospital calls) when billing in conjunction with a surgery where the patient is admitted as an inpatient or outpatient at a hospital. The pre-operative exam and all other related services are reimbursed within the billed surgery codes. Do not submit for them separately.

INTERNAL CONTROL NUMBER (ICN)

This term refers to the Internal Control Number (ICN) assigned by the Claims Processing Agent to each claim submitted.

See: Provider Manual

INTERPRETER

Interpreter services are reimbursable when the Dentist or Oral Surgeon pays an interpreter to interpret for a beneficiary who does not speak the same language as the physician/staff or to use sign language for interpretation with a hearing impaired beneficiary. Services for Interpreters can **ONLY** be billed on a CMS-1500 08/05 Claim Form. One unit of service is equal to 15 minutes. If more than one hour of interpretation is needed, providers may bill for the additional time. These services do not count toward the adult maximum benefit.

MEDICAL NECESSITY

The OVHA definition of medical necessity is described in the Welfare Assistance Manual Section M107. A copy of this rule can be found on the OVHA web site.

MODIFIERS

The OVHA permits the use of a modifier to indicate a pregnant/parenting woman's program. The modifier "HD" may be used to submit a HIPAA compliant transaction. The previously established modifier of "P" will remain acceptable for use by providers who have not yet converted to the HIPAA transaction sets. Providers billing on paper at the time of this writing may bill using the "HD" or "P" modifier until notified further.

ORAL SURGERY

Services, which are by definition medical, must be submitted on the CMS-1500 08/05 Claim Form using current CPT codes. However, if there is a CDT code on file for the services provided, the provider may bill on the accepted American Dental Association Claim Form using CDT codes.

Note: D7510 incision and drainage of abscess requires the appropriate tooth number to be referenced on the claim form.

See: CMS-1500 08/05 Supplement

PLACE OF SERVICE CODES

Place of Service Codes are required on the medical claim form (CMS-1500 08/05). For a complete list of the codes refer to the CMS-1500 08/05 manual.

PRIOR AUTHORIZATION

Dentists and Oral Surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the VTMedicaid Fee Schedule and the Dental Procedure/Fee Schedule. Requests for Dental prior authorization must be sent to:

The Vermont Department of Health, Office of Oral Health
P.O. Box 70
108 Cherry Street
Burlington, VT 05402
(802) 863-7341 (800) 464-4343 ext. 7341

Requests for medical prior authorization must be obtained from the OVHA.

See: CMS-1500 08/05 Supplement
Prior Authorization Supplement

RADIOGRAPHS

Radiographs should never be sent to the Medicaid processing agent when submitting claims. Radiographs are required when submitting PA requests to Dental Health Services for orthodontic treatment.

See: Dental Procedure/Fee Schedule

SEALANTS

Pit and fissure sealants are covered by Vermont Medicaid for beneficiaries under age 21. The sealant procedure codes are D1351 (limited to first and second permanent molars) and D1352 (limited to deciduous second molars and bicuspids). These codes are limited to once per tooth per five years. Providers are reminded that once a sealant is replaced the provider is responsible for maintenance of the sealant for five years. The surfaces eligible for sealants are limited to O (alpha), B, L, OB and OL. No payment will be made for this service after a restoration of the occlusal surface.

SERVICE LIMITATIONS

There are service limitations on certain dental procedures. These limitations include:

- One comprehensive oral evaluation per beneficiary per provider/per lifetime (D0150)
- One periodic oral evaluation per beneficiary per 180 days (D0120)
- One prophylaxis per beneficiary/per 180 days (D1120, D1110)
- One complete series of radiographs per beneficiary/per two years and/or

- One panoramic film per beneficiary/per two years (D0210, D0330)
- Restorations are limited to one identical restoration per tooth per year

SPEND-DOWN

Some persons become eligible for Medicaid benefits only after incurring a specific amount of healthcare costs over a specific period. Medicaid eligibility for this type of case begins on any day of the month in which the person incurs the specified amount. When the person is determined to be eligible for Medicaid, the district worker sends a letter to the provider informing the provider that the spend-down amount has been met or that a remaining amount should be deducted from a particular bill before billing Medicaid for the remainder.

Claims, which are submitted with the first day of eligibility as the date of service, must have the spend-down letter from the district office attached to the claim form. If the spend-down letter is not attached to the claim form, the claim will be denied.

To complete the claim form involving spend-down, the provider must do the following:

- Bill their usual and customary charge
- Write "Spend-down $(dollar amount)" in the remarks section of the claim
- Total all detail charges billed
- The amount of spend-down must be entered in the other insurance payment field
- The Notice of Spend-Down Determination form is required to be attached to the claim

Your reimbursement will be the Vermont Medicaid allowed amount, less the spend-down amount.

SUPERNUMERARY TEETH

The Vermont Department of Health uses the ADA approved coding system in regard to billing for supernumerary teeth.

Permanent supernumerary teeth are identified using the numbers 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81 and 82. This coding system begins with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. For example: supernumerary tooth number 51 is adjacent to the upper right third molar number 1 and supernumerary tooth 82 is adjacent to the lower right third molar number 32.

Primary (baby) supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth. For example: supernumerary "AS" is adjacent to "A". The list of primary supernumerary teeth is: AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS and TS.

TMJ DEVICE

Vermont Medicaid reimburses for TMJ Splints. Providers may bill for beneficiaries receiving this device on the CMS-1500 08/05 or the dental claim form. D7880 is the procedure code to be used. The TMJ Splint is not considered part of the annual adult maximum benefit and does not require Prior Authorization (PA).

UNLISTED SERVICES

Some covered services may not be classified or the classification may be difficult to determine. Providers may contact the Dental Health Services Division for assistance in determining the appropriate procedure code for billing.

USUAL AND CUSTOMARY CHARGES

Various claim forms (1500, UB-92, and 837) require the submission of "Charge" or "Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insured and private-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid; except, if the charge has been reduced on an individual basis because of a sliding-fee scale based on the patient's documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid beneficiaries by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above re sliding-fee scale.

1.4 PROCEDURE CODES

A list of procedure codes for Dental services can be obtained by contacting the Provider Services Unit. It includes the code, name of the procedure, rate on file and coverage criteria. Dental codes subject to prior authorization and/or limits can be found in the Dental Procedure/Fee Schedule. This information is also available on the OVHA web site referenced in the introduction section of this manual. The procedure codes listed in Dental Procedure/Fee Schedule must be billed on the acceptable Dental Claim Form.

The OVHA will inform the providers of changes in the price on file. The first official notice of a price change may be in a Remittance Advice. The OVHA reserves the right to change the reimbursement rate on file for any item or service without prior notice. For these reasons providers should be careful to retain the changes noted in the RAs. Although the OVHA will attempt to keep the Fee Schedule 100% accurate, the actual rate recorded in the computer system for reimbursement is the only accurate rate for the applicable date of service.

See: Dental Procedure/Fee Schedule
Claim Form Section

1.5 DENTAL CLAIM FORM (1994)

All information on the Dental claim form should be typed or legibly printed. The fields listed below are used by the Claims Processing Agent when processing Vermont Medicaid claims received on the 1994 ADA version. The fields designated by an asterisk (*****) are mandatory; other fields are required when applicable. The fields not listed below are not used in the Vermont Medicaid Program and do not need to be completed.

FORM LOCATOR	REQUIRED INFORMATION
2. Medicaid/EPSDT	Check Medicaid **and** EPSDT if it is appropriate to the age of the beneficiary.
3. Carrier name and address	Enter "Vermont Medicaid."
4. Patient name*****	Enter the patient's first name, middle initial, and last name.
6. Sex	Check appropriate box, male or female.
7. Patient birth date	Enter the beneficiary's date of birth. If the beneficiary was born in any century other than the 1900s, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in a MM/DD/YY format.
8. If full time student	Enter your patient's account number. The system can accept up to twelve digits in this field. This information will be printed on the RA summary for your accounting purposes.
10. Employee/subscriber soc. sec. or I.D. number*	Enter the beneficiary's nine digit Medicaid I.D. number.
14. Is patient covered by another dental plan?*	Indicate the appropriate answer, yes or no.
15a. Name and address of carrier(s)	If the beneficiary has other health insurance (excluding Medicare), enter the insurance carrier's name and address.
15b. Group no.(s)	For claims that involve other insurance, enter the appropriate carrier codes of the other insurance(s) involved. Enter also the corresponding policy number(s).

21. Name of Billing Dentist or Dental Group*	Enter the Medicaid provider name and number as they appear on the Vermont Medicaid Provider Agreement Form. This is the group or individual practice to which the check will be issued.
22. Mailing address*	Enter the address where payment should be remitted and the Medicaid provider number of the dentist who performed the service in the right hand side of this field directly beneath the number in Field 21. Required even when this number is the same as in Field 21 above.
30. Is treatment result of occupational illness or injury*****	Check the appropriate box, yes or no.
31. Is treatment result of auto accident?*****	Check the appropriate box, yes or no.
32. Other accident?*****	Check the appropriate box, yes or no. If any box in 30, 31, or 32 indicates a "Yes" response, enter the date of the accident in the corresponding field.
37. Examination and Treatment Plan:	
Tooth # or letter	Enter the appropriate tooth number or letter as indicated on the chart at the left of the claim form, if applicable.
Surface	Enter the appropriate letter(s) to indicate the surface(s) of the tooth on which the service is performed, if applicable. B Buccal D Distal F Facial I Incisal L Lingual M Mesial O Occlusal

	Description of service	Describe the procedure.
	Date service performed*	Enter the date of each service provided.
	Procedure number*	Enter the appropriate procedure code. It is not necessary to enter the leading zero or zeroes. For ECS, enter the five-digit procedure code.
	Fee*	Enter the usual and customary charge for the service rendered.
39.	Signed - Date*	Enter the Vermont Medicaid provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.
41.	Total Fee Charged*	Calculate the total of all charges from each detail and enter the amount.
42.	Carrier pays	Enter the amount paid by other health insurance coverage (excluding Medicare). If this field is completed fields 15a and 15b must be completed.

1.6 DENTAL CLAIM FORM (1999)

All information on the Dental claim form should be typed or legibly printed. The fields listed below are used by the Claims Processing Agent when processing Vermont Medicaid claims received on the 1999 ADA version. The fields designated by an asterisk (*****) are mandatory; other fields are required when applicable. The fields not listed below are not used in the Vermont Medicaid Program and do not need to be completed.

FORM LOCATOR	REQUIRED INFORMATION
2. Medicaid/EPSDT	Check Medicaid **and** EPSDT if it is appropriate to the age of the beneficiary.
3. Carrier name	Enter "Vermont Medicaid"
8. Patient name*	Enter the patient's last name, first name and middle initial
12. Patient date of birth	Enter the recipient's date of birth. If the recipient was born in any century other than the 1900's, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in a MM/DD/YY format.
14. Sex	Check appropriate box, male or female.
19. Subs./Emp.ID#/SSN#	Enter the Medicaid ID# of the patient.
31. Is patient covered by another plan?*	Indicate the appropriate answer, yes or no. If yes, check appropriate box, Dental, Medical or Both.
36. Plan/Program Name	If the recipient has other health insurance (excluding Medicare), enter the insurance carrier's name.
42. Name of Billing Dentist or Dental Group*	Enter the provider name as it appears on the Vermont Medicaid Provider Agreement Form. This is the group or individual practice to which the check will be issued.
44. Billing Provider ID*	VT Medicaid provider number. Use your group provider number if you are a provider in a group practice. Use your individual provider number if you are not a provider in a group practice.

46,50,51,& 52. Mailing address*	Enter the address where payment should be remitted and the Medicaid provider number of the dentist who performed the service in the right hand side of field 46.
46. Attending Provider ID*	VT Medicaid provider number of attending dentist who performed the service. (Write in after address)
56. Is treatment result of occupational illness or injury*	Check the appropriate box, yes or no.
57. Is treatment result of auto accident?*	Check the appropriate box, yes or no.
57. Other accident?*	Check the appropriate box, yes or no. If any box in 56 or 57 indicates a "Yes" response, enter the date of the accident in the corresponding field.
59. Examination and Treatment Plan:	
Date service performed*	Enter the date of each service provided
Tooth # or letter	Enter the appropriate tooth number or letter as indicated on the chart at the left of the claim form, if applicable.
Surface	Enter the appropriate letter(s) to indicate the surface(s) of the tooth on which the service is performed, if applicable.

B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial
O	Occlusal

Procedure Code*	Enter the appropriate procedure code. It is not necessary to enter the leading zero or zeroes. For ECS, enter the five-digit procedure code.
Description of service	Describe the procedure.
Fee*	Enter the usual and customary charge for the service rendered.
Total Fee Charged*	Calculate the total of all charges from each detail and enter the amount.
Paymment by Other Plan *	Enter the amount paid by other health insurance coverage (excluding Medicare).
62. Signed -Date*	Enter the Vermont Medicaid provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.

1.7 DENTAL CLAIM FORM (2002)

All information on the dental claim form should be typed or legibly printed. The fields listed below are used by the Claims Processing Agent when processing Vermont Medicaid claims received on the 2002 version of the ADA claim form. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The fields not listed below are not used in the Vermont Medicaid Program and do not need to be completed.

	FORM LOCATOR	REQUIRED INFORMATION
1.	EPSDT/Title XIX	Check EPSDT/Title XIX if it is appropriate to the age of the patient.
3.	Primary Payer Information	Enter "Vermont Medicaid".
4.	Other Dental or Medical Coverage?*	Indicate the appropriate answer, yes or no.
11.	Other Carrier Name	If the patient has other health insurance (excluding Medicare), enter the insurance carrier's name.
15.	Subscriber Identifier (SSN)*	Enter the patient's 9 digit Medicaid ID number.
20.	Patient Name*	Enter the patient's last name, first name and middle initial.
21.	Patient date of birth	Enter the patient's date of birth. If the patient was born in any century other than the 1900's, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in a MM/DD/YY format.
22.	Gender	Check the appropriate box, M or F.
24.	Procedure Date*	Enter the date of each service provided.
27.	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number or letter as indicated on the chart in box 34 when the procedure code reported involves a tooth.
28.	Tooth Surface	Enter the appropriate letter(s) to indicate the surface(s) of the tooth when the procedure code reported involves a tooth. Enter up to five of the following codes:

B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial

		O Occlusal
29.	Procedure Code*	Enter the appropriate five-digit procedure code.
30.	Description of Procedure	Enter the description of procedure.
31.	Fee*	Enter the usual and customary charges for each service rendered.
33.	Total Fee*	Calculate the total of all charges from all fees entered in 31 and enter the amount.
35.	Payment by Other Plan*	Enter the amount paid by other health insurance coverage in the remarks section.
45.	Is treatment result of occupational illness/injury, auto accident or other accident?	If applicable, check a box.
46.	Date of Accident	If applicable, enter the date of the accident indicated in box 45.
48.	Name and Billing Address of Billing Dentist or Dental Group*	Enter the provider name and address as it appears on the Vermont Medicaid Provider Agreement Form. This is the group or individual practice to which the check will be issued.
49.	Billing Provider ID*	Enter the Vermont Medicaid provider number. Use your group provider number if you are a provider in a group practice. Use your individual provider number if you are not a provider in a group practice.
53.	Signed-Date*	Enter the Vermont Medicaid provider's signature or facsimile, of signature of the provider's authorized representative. Enter the date of the signature.
54.	Attending Provider ID*	Enter the Vermont Medicaid provider number of the attending dentist who performed the service.

1.8 DENTAL CLAIM FORM (2006)

The ADA has issued this new billing form to accommodate the National Provider Identification number. The changes made to the form are minimal and the instructions for filling out the new form locators are given below.

All information on the dental claim form should be typed or legibly printed. The fields listed below are used by the Claims Processing Agent when processing Vermont Medicaid claims received on the 2006 version of the ADA claim form. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The fields not listed below are not used in the Vermont Medicaid Program and do not need to be completed.

	FORM LOCATOR	REQUIRED INFORMATION
1.	EPSDT/Title XIX	Check EPSDT/Title XIX if it is appropriate to the age of the patient.
3.	Primary Payer Information	Enter "Vermont Medicaid".
4.	Other Dental or Medical Coverage*	Indicate the appropriate answer, yes or no.
11.	Other Carrier Name	If the patient has other health insurance (excluding Medicare), enter the insurance carrier's name.
15.	Subscriber Identifier (SSN)*	Enter the patient's 9 digit Medicaid ID number.
20.	Patient Name*	Enter the patient's last name, first name and middle initial.
21.	Patient date of birth	Enter the patient's date of birth. If the patient was born in any century other than the 1900's, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in a MM/DD/YY format.
22.	Gender	Check the appropriate box, M or F.
23.	Patient ID/Account Number	Enter the patient identification/account number.
24.	Procedure Date*	Enter the date of each service provided.
27.	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number or letter as indicated on the chart in box 34 when the procedure code reported involves a tooth.
28.	Tooth Surface	Enter the appropriate letter(s) to indicate the surface(s) of

		the tooth when the procedure code reported involves a tooth. Enter up to five of the following codes: B Buccal D Distal F Facial I Incisal L Lingual M Mesial O Occlusal
29.	Procedure Code*	Enter the appropriate five-digit procedure code.
30.	Description of Procedure	Enter the description of procedure.
31.	Fee*	Enter the usual and customary charges for each service rendered.
33.	Total Fee*	Calculate the total of all charges from all fees entered in 31 and enter the amount.
35.	Payment by Other Plan*	Enter the amount paid by other health insurance coverage, spend down, or payment received from the recipient toward GA voucher, in the remarks section.
45.	Is treatment result of occupational illness/injury, auto accident or other accident	If applicable, check a box.
46.	Date of Accident	If applicable, enter the date of the accident indicated in box 45.
48.	Name and Billing Address of Billing Dentist or Dental Group*	Enter the provider name and address as it appears on the Vermont Medicaid Provider Agreement Form. This is the group or individual practice to which the check will be issued.
49.	Billing Provider NPI Number*	Enter the billing provider NPI number. Use your group provider NPI number if you are a provider in a group practice. Use your individual NPI number if you are not a provider in a group practice.

52A	Billing Taxonomy Code*	Enter the taxonomy code for the group practice. If you are not a provider in a group practice and you are using NPI numbers, use this box for the taxonomy code for the attending dentist who performed the service.
53.	Signed-Date*	Enter the Vermont Medicaid provider's signature or facsimile, of signature of the provider's authorized representative. Enter the date of the signature.
54.	Attending Provider NPI number*	Enter the Attending Provider NPI number. Use the NPI number of the attending dentist who performed the service.
56A	Taxonomy Code*	Enter the taxonomy code of the attending dentist who performed the service.
58	Attending Provider ID	Enter the seven character Vermont Medicaid Attending Provider ID number. Use the provider number of the attending dentist who performed the service.